STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 88708-001**

v

Midwest Security Life Insurance Company
Respondent
_____/

Issued and entered
This 3rd day of July 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On March 25, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the material submitted and accepted the request on April 1, 2008.

The Petitioner receives health care benefits as an eligible dependent under her husband's coverage with Midwest Security Life Insurance Company (Midwest) through his employer. The Commissioner notified Midwest of the external review and requested the information used in making its adverse determination.

Because this case involves medical issues, the Commissioner assigned it to an independent review organization (IRO) which provided its recommendation to the Commissioner on June 4, 2008.

II
FACTUAL BACKGROUND

On January 29, 2007, the Petitioner had a physical examination from her obstetrician/gynecologist, XXXXX, D.O. Following this visit, Dr. XXXXX ordered certain tests which were performed on January 31, 2007, at XXXXX. Midwest covered the tests as services done for "treatment of a general illness" and applied the cost ($692.50) to the Petitioner's network deductible under the terms of the certificate. Dr. XXXXX and XXXXX are in Midwest's PPO network.

The Petitioner appealed Midwest's decision. Midwest's grievance committee reviewed the appeal but maintained the decision. The Petitioner exhausted Midwest's internal grievance process and received a final adverse determination dated March 4, 2008.

III
ISSUE

Did Midwest correctly process the Petitioner's claims for laboratory services?

IV
ANALYSIS

Petitioner's Argument

On January 29, 2007, the Petitioner had an examination with Dr. XXXXX that included a Pap smear. As part of the examination, Dr. XXXXX ordered what he called "routine blood work with an additional test for the prolactin due to heavy menses."

Dr. XXXXX attempted on several occasions to make it clear that the Chem 12, CBC, lipid, and thyroid tests were done on a routine basis. Dr. XXXXX says that he orders these tests (except the prolactin level test) with all routine physicals. He initially submitted the examination and laboratory tests with several diagnoses although he considers them to be routine. At the Petitioner's request, Dr. XXXXX sent letters and progress notes to Midwest to demonstrate that the Chem 12, CBC, lipid, and thyroid tests were routine.

The Petitioner believes that the laboratory tests should be covered with no deductible or coinsurance as part of her yearly visit with her physician.

Midwest Security Life Insurance Company's Argument

In its final adverse determination, Midwest said:

> All documentation was reviewed by the [grievance] Committee members. This documentation included any medical records and all correspondence. These claims were billed as diagnostic treatment of a medical condition as your practitioner originally submitted these charges with the diagnosis of Anemia-285.9. Because these services were done for treatment of a general illness, coverage is allowed under your general illness benefits, of which is subject to your deductible then co-insurance rates. Therefore, these charges were applied to your deductible correctly as the services rendered were for treatment of a medical condition. For any additional reconsideration of your charges under your Routine benefit submission of clinical notes is required.

Midwest says it processed the claim correctly according to the terms of the certificate.

Commissioner's Analysis

Under the terms of the Petitioner's group health plan, she is responsible for a deductible for network services. However, the plan also contains this provision:

> If the PPO plan is elected, the Plan will cover, except as noted, the medical fee of the attending Physician and the associated diagnostic x-ray and laboratory expense for routine physical, vision, and hearing examination. This coverage is subject to a $500 maximum benefit per Covered Person per Year. A copayment, which applies per routine examination, is stated above. This benefit is not payable for the expenses incurred for a diagnosis that is being made of a specific Injury or Sickness.
>
> No benefits will be paid under this additional coverage for: (1) a medical examination which is made with respect to an Injury or Sickness; (2) a medical examination which is made with respect to (i) an abortion (ii) a miscarriage; (iii) childbirth; or (iv) a pregnancy in general; (3) an examination which is made for the extraction of teeth or for any other dental treatment; (4) a medical examination required by a third party, such as an examination required for occupation, employment, school, athletics, travel or the purchase of insurance; or (5) a medical examination performed outside the PPO network.

Under this provision, routine (or screening) laboratory tests are covered subject to a $500.00 maximum benefit per year. Generally, a "routine" or "screening" test is done for

seemingly well individuals who have no signs or symptoms of illness or disease so that problems can be detected early and treatment can be provided. A "diagnostic test" is done when there is an identifiable problem in order to determine the cause of the disorder. Under this provision, routine or screening tests are covered but diagnostic tests are not. (Diagnostic tests are covered elsewhere under the certificate but are subject to co-pays and/or deductible requirements.

The Petitioner says the examination she had on January 29, 2007, was her annual physical. However, it appears to the Commissioner that the examination may have been both routine and for a specific problem (i.e., hypermenorrhea).

To assist the Commissioner in determining which, if any, of the laboratory tests the Petitioner received on January 31, 2007, were for routine or screening purposes, this matter was referred to an IRO for the recommendation of an expert. The IRO expert is certified by the American Board of Obstetrics and Gynecology and is in active clinical practice. The IRO report said:

> The treating physician ordered laboratory tests…that were performed on January 31, 2007.
>
> The laboratory tests are identified in the record as CPT codes:
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> 36415 venous venipuncture
> 80053 comprehensive metabolic panel (albumin, bilirubin, total, calcium, carbon dioxide, chloride, creatinine, glucose, phosphatase alkaline, potassium
> 80061 lipid panel (cholesterol, serum, total, lipoprotein, direct measurement, high-density cholesterol (HDL), triglycerides
> 84146 prolactin
> 84439 thyroxine, free
> 84443 thyroid stimulating hormone (TSH)
> 84480 trilodothyronine T3; total (TT-3)
> 85025 blood count complete CBC, automated (Hgb, Hct, RBC, WBC, platelet count), automated differential white blood count
>
> * * * Apparently the claims were billed as diagnostic treatment of a medical condition as the treating physician originally submitted these charges with the diagnosis of Anemia 285.9. According to [Midwest], because these services were done for treatment of a general illness,

> coverage is allowed under [the Petitioner's] general illness benefit of which is subject to her deductible then coinsurance rates.
>
> In the opinion of the Reviewer, to evaluate the [Petitioner's] symptoms of hypermenorrhea, thyroid function studies (CPT codes 84439, 84443, and 84480) and a prolactin (84146) level would be appropriate and could identify a hormonal imbalance. The imbalance could be due to a variety of reasons that would cause the [Petitioner's] "very heavy" menstruation bleeding. Therefore, these laboratory tests are considered diagnostic.
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> The other tests (CPT codes 80053, 80061, and 85052) including the venous venipuncture (CPT code 36415) to obtain the blood samples for testing are all considered routine screening tests when done as part of an interval examination. In addition, these tests are done to look for signs of common (and sometimes difficult to diagnose on history and physical examination) diseases such as anemia, kidney failure or abnormal cholesterol levels.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO recommendation is afforded deference by the Commissioner; in a decision to uphold or reverse an adverse determination the Commissioner must cite "the principal reason or reasons why the Commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16)(b). The IRO's analysis is based on expertise and professional judgment and the Commissioner can discern no reason why that judgment should be rejected in the present case.

Therefore, the Commissioner accepts the opinion of the IRO and finds that the tests with CPT codes 84439, 84443, 84480, and 84146 were diagnostic tests performed because of the Petitioner's complaint of hypermenorrhea and are therefore subject to the annual deductible. The Commissioner further finds that the tests with CPT codes 80053, 80061, 85052, and 36415 were routine screening laboratory tests that were part of her routine physical and should be covered subject only to the $500.00 benefit maximum for such routine services.

V
ORDER

The Commissioner reverses in part Midwest Security Life Insurance Company's March 4, 2008, final adverse determination. Midwest shall reprocess the claims for CPT codes

80053, 80061, 85052, and 36415 as routine screening laboratory tests that were part of a routine physical and subject only to the $500.00 benefit maximum for such routine services. The remaining tests, CPT codes 84439, 84443, 84480, and 84146, were diagnostic tests performed because of the Petitioner's complaint of hypermenorrhea and were therefore subject to the annual deductible.

Midwest shall comply with this Order within 60 days of the date of this Order, and shall, within seven days of compliance, provide the Commissioner proof it has implemented the Order.

To enforce this Order, the Petitioner must report any complaint regarding the implementation of this Order to the Office of Financial and Insurance Regulation, Health Plans Division, toll free 877-999-6442.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.